

A new specialty of Acute In-patient Psychiatry? Commentary.

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Luiz Dratcu makes a case for a new specialty of acute in-patient psychiatry; Frank Holloway argues otherwise. In neither case are the arguments at all surprising. In both cases they are eloquently expressed. The case for a new specialty is based upon recognition of a continuing need for acute psychiatric in-patient services, recognition that these require particular skills and facilities, and acknowledgement that these are likely to be most efficiently and effectively provided where interests and activities are focused upon them. The case against does not deny the need for attention to widely acknowledged shortcomings of many acute psychiatric in-patient services, but it does ask the questions "what should constitute a specialty?", and "what benefit would flow from having a specialty and for whom?".

Thus, both authors acknowledge a need to attend to the acute inpatient setting. Recent years have seen a whole series of publications drawing attention to shortcomings of acute psychiatric in-patient services (e.g. Sainsbury Centre 1998, Department of Health 2002, Rix and Shephard 2003, Mental Health Act Commission 2005, Braithwaite 2006, Garcia et al 2005). Recurrent issues are poor communications with community staff, service users' experiences of an unsafe, threatening environment, social and geographic isolation, lack of clarity of purpose around the admission and its context, and processes of management decision making that are highly dependent upon "ward rounds".

This chorus of discontent is not a response to sudden, recent deterioration in the quality of service on offer; rather it reflects a timely and appropriate rise in the level of expectations. The most recent (11th) Biennial Report from the Mental Health Act Commission is probably the most critical to date. That is not because matters have worsened significantly since publication of the 10th. Recent years have seen long overdue attention to matters such as human rights, gender and racially sensitive characteristics, and power relations within mental health settings. These are all particularly pertinent and challenging when considered alongside traditional acute psychiatric in-patient practices.

October 2005 saw publication of the outcome of consultations about the role of the consultant psychiatrist (Royal College of Psychiatrists and National Institute for Mental Health in England 2005). The publication draws attention to the multidisciplinary nature of mental health services and the activities that they support. Conclusions include the view that it is no longer tenable for the consultant psychiatrist to assume full responsibility for, and influence over, all aspects of care provided to community-based recipients of complex systems of care. It is the need to consider the implications of this upon the consultant's contribution to the acute psychiatric in-patient unit that prompts the current debate. It has acquired relevance by the development of a National Acute Inpatient Mental Health Project Board which is acting as a formal reference group for the Health Care Commission, setting standards against which to audit acute psychiatric in-patient care.

In addition to the now well established and respected pioneering work at Guy's (Dratcu et al 2003) a number of other units have experimented with, or considered developing consultant roles that are either exclusively inpatient or exclusively community based. Detailed feedback is being assembled. Initial reflections are that the journey has not been an easy one for everyone. However, even where this approach is felt to have contributed service and working life improvements, there is no clarity about whether or not this is dependent upon, or could be enhanced by according the activity "specialist" status.

In many ways pitching a debate such as this around interpretations of an arbitrary term such as "specialist" distracts from other more pressing concerns. Recurrent criticisms of the quality and nature of acute inpatient services are not specifically directed against the consultant. They are much more holistic and refer to the extent to which a period of acute psychiatric in-patient treatment constitutes and is experienced as part of a "journey" through a larger system of care, ways in which power is experienced and exercised within what is very often a coercive environment, and the physical characteristics of the facilities within which acute inpatient care is practiced. None of these are likely to be usefully addressed simply by defining another set of

sub-specialist competencies of relevance to only one of the several contributing professions. All are likely to be responsive to clarity of purpose, commitment and leadership amongst those involved. Furthermore contexts differ and solutions appropriate to one setting are by no means necessarily applicable to another. What might be an entirely appropriate *modus operandi* in Central London may not be applicable to a rural setting. Could the same flexibility apply to a professional accreditation?

Attention to the shortcomings of acute psychiatric in-patient services requires change, and there are signs that policy makers are prepared to motivate NHS provider organisations accordingly. At the same time there are open reflections upon the contributions the consultant psychiatrist (and by implication, psychiatry as a professional discipline) makes to a multidisciplinary mental health service. The former requires leadership, creativity and commitment. These might well be supplied by a consultant psychiatrist who happens to have appropriate personal qualities, but they are not likely to arise simply because an individual has captured a further set of professional qualifications. Consideration of the part played by the psychiatrist in acute in-patient settings has to include honest reflection upon whether or not traditional practices invariably support patients' experiences of a whole system of care, from community setting through the inpatient unit and out again. Particular concerns are the pros and cons of medical or crisis-team "gate-keeping", the value, status and conduct of the "ward round", the pros and cons of "continuity of care", which can result in ward staff having to relate to multiple medical teams and the development of non-medical prescribing.

Answers to these are likely to differ from place to place and from team to team. In seeking a solution it might be more appropriate to focus upon how best to provide as smooth and as appropriate a "patients journey" within a defined setting and with the individuals available, than attempting to define an organisational structure that all patients and professionals are then shoe-horned into. Where there is a consultant psychiatrist keen to take the lead on developing acute psychiatric in-patient services then that person might be the most appropriate to do it.

That should not prevent capable leaders from other backgrounds coming forward when they might be the more appropriate, just because there is a notion that each acute psychiatric in-patient unit should be lead by a specialist Acute In-patient Psychiatrist.

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